

Commonwealth Of Kentucky Health Insurance Application PY 2006

(for Use By the **Kentucky Retirement Systems**)

MAIL APPLICATION TO:

Perimeter Park West
1260 Louisville Road
Frankfort, KY 40601

INSURANCE COORDINATOR SECTION

Insurance Effective Date

		/			/				
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Company Number

8	0	0	0	0
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Sp Gen

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HD?

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Reason for Application

☐ < New Retiree ☐ < Open Enrollment ☐ < COBRA ☐ < Previously Waived* ☐ < Other*

* If you Previously Waived or marked "Other", enter the Qualifying Event Date
AND a description of the Qualifying Event:

Date

Description

SECTION I: DEMOGRAPHIC INFORMATION

Is retiree applying
for this coverage?

☐ Yes ☐ No

If "NO", what is your relationship to the retiree?

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RETIREE

(Required)

SSN

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Retiree Name (First, MI, Last)

APPLICANT

(If retiree is not applying)

SSN

--	--	--	--	--	--	--	--	--	--

Applicant Name (First, MI, Last)

APPLICANT Specific Information

Street Address

PO Box / Apt. #

Date of Birth

		/			/				
Month		Day		Year					

City, State, Zip Code

County of Residence

Country/Mail Code -- If NOT U.S.A.

() -

Primary Phone Number

Applicant's Email Address

Smoking Status (Required)

Were you a smoker
on 7/1/05?

Yes ☐ No ☐

Gender

☐ < Male
☐ < Female

Marital Status

☐ < Married
☐ < Single

SECTION II: PLAN SELECTION

1. Plan Code

If electing coverage, enter 143 &
complete this Section. If waiving,
enter 999 and go to Section VII.

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Reason for waiving,
if applicable

2. Option

(Check only one)

☐ < Commonwealth Essential
☐ < Commonwealth Enhanced
☐ < Commonwealth Premier

3. Level of Coverage

☐ < Single ☐ < Couple
☐ < Parent Plus ☐ < Family

4. Cross-Reference

☐ < Yes
If Yes, you must complete
Sections III and IV

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION

If you elected Single in Section II, box 3, go to Section VI on Page 2.

Social Security Number	Name (First, MI, Last)	Gender (Circle One)	Date of Birth (MM/DD/YYYY)	Relationship Code
		M F		
		M F		
		M F		
		M F		
		M F		

SECTION IV: SPOUSE'S CROSS-REFERENCE INFORMATION

Complete ONLY if you checked Yes in Section II, box 4 above.

Company Number: (REQUIRED) <table border="1"><tr><td></td><td></td><td></td><td></td><td></td></tr></table>						Dual Employee Indicator, if applicable: <input type="checkbox"/>	Was spouse a smoker on 7/1/05? (REQUIRED) <input type="checkbox"/> Yes <input type="checkbox"/> No	Is spouse a Hazardous Duty Retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse's Hire Date or Retirement Date: ____/____/____	Spouse's Deduction Start Date (If BOE employee): ____/____/____

SECTION V: CUSTODIAL PARENT INFORMATION

Dependent(s) listed that do not live with you may only be covered if you or your spouse have a court or administrative order requiring insurance coverage for health care expenses of the child. Coverage provided due to a court or administrative order may not be terminated without proper documentation.

Dependent's Social Security Number

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Custodial Parent Name

All Dependents? ☐ < Yes

Custodial Parent Address

Country / Mail Code (If not USA)

Retiree's SSN

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Applicant's SSN(from Page 1, Section I)

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SECTION VI: NOT APPLICABLE

Retirees are not eligible to participate in a Flexible Spending Account Program.

If a retiree elects to pay by cross-reference with an active spouse and the active spouse is eligible and would like to enroll in the state's Flexible Spending Account Program (Commonwealth Choice), the active spouse and the retiree should make their health coverage elections by completing the spouse's (active employee) health insurance application.

SECTION VII: AUTHORIZATION AND CERTIFICATION

- * My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge.
- * I understand that all benefits for my eligible dependents and me will be provided in accordance with the plan contract.
- * I agree to abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled.
- * I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- * I understand that any material misrepresentation or material omission contained herein may be used to reduce or deny a claim or void the contract.
- * I authorize the Retirement System to release the information in this application to the Social Security Administration. The information in this application may be used by the Social Security Administration to determine Medicare eligibility. I further acknowledge that Medicare eligibility may affect my participation in the retiree health insurance plan.
- * I agree that the selected benefits may only be changed during Open Enrollment or in connection with a Qualifying Event.
- * I authorize the Retirement System to deduct from my retirement benefits the amount required to cover my share of the health insurance benefits I have selected.
- * My signature below certifies that I have read the Health Insurance Handbook and agree to be bound by its terms and conditions. All information listed on this application was completed with knowledge of the Handbook's terms and conditions, and I accept full responsibility for any deficiency concerning my application due to a failure to conform to the Handbook's terms and conditions.

Retiree Signature

Date

Applicant Signature (if other than Retiree)

Date

Spouse Signature
(only REQUIRED if electing to pay by cross-reference)

Date

Retirement Insurance Coordinator Signature

Date

Signature of Spouse's Insurance Coordinator
(only REQUIRED if electing to pay by cross-reference)

Date

Health Insurance Application Instructions -- PAGE 1
KENTUCKY RETIREMENT SYSTEMS

Reason for Application

- **New Retiree:** Check this box if you are a new retiree of the Kentucky Retirement Systems.
- **Open Enrollment:** Check this box if you are filling out this application due to Open Enrollment.
- **COBRA:** Check this box if you are applying for COBRA coverage (Your Insurance Coordinator will mail this application and your initial payment).
- **Previously Waived:** Check this box if you previously waived your health insurance coverage and have now experienced a qualifying event that allows you to select health insurance coverage. You must provide the date and description of the qualifying event in the spaces provided below. All other qualifying events do not require an application and do require an ADD or DROP Form Only. You may request an ADD or DROP Form from your Insurance Coordinator and must provide supporting documentation, as required.
- **Other:** Check this box if none of the listed options apply. The Insurance Coordinator must provide a date and an explanation if "Other" is selected.

NOTE TO THE INSURANCE COORDINATOR: Complete the information requested within the box in the top right hand corner of the application.

- Enter the effective date of coverage.
- Check the Sp Gen box if the retiree is being assigned health insurance coverage by KRS.
- Enter Y or N to indicate whether or not the retiree is a hazardous duty retiree.

SECTION I: DEMOGRAPHIC INFORMATION – Please PRINT clearly.

- If you are not the retiree and you are applying for health insurance coverage, enter your relationship to the retiree (SP = Spouse or CH = Child)
- **RETIREE:** If you are the retiree, enter your Social Security Number and your name (First, MI, Last) and go to *Applicant Specific Information* below.
- **APPLICANT:** If you are not the retiree:
 - Enter the retiree's Social Security Number and the retiree's name (First, MI, Last) in the space labeled *Retiree* above.
 - Enter your Social Security Number and your name (First, MI, Last) under *Applicant*.
 - Go to *Applicant Specific Information*.
- **APPLICANT Specific Information:**
 - Enter the planholder's Address (including County of Residence), Date of Birth, Primary Phone Number, Planholder's email address, if available, Smoking Status, Gender and Marital Status in this Section.
Note: If the smoking status flag is not checked, this application will be Pended until the information is provided.

SECTION II: PLAN SELECTION

1. Plan Code:

- If you are electing coverage, enter **143** and complete the remainder of this Section.
- If you are waiving coverage, enter **999** and skip to Section VII on Page 2.

If you are waiving coverage, enter the reason for waiving in the space provided.

2. Option: Mark the box that indicates the option you are selecting. For a description of each option, see the Health Insurance Handbook. **Select only one.**

3. Level of Coverage: Mark the box that indicates the level of coverage you are selecting. For a description of each level of coverage, see the Health Insurance Handbook. **Select only one.**

Health Insurance Application Instructions -- PAGE 1 Continued...
KENTUCKY RETIREMENT SYSTEMS

4. **Cross-reference:** If you wish to pay by cross-reference, mark this box and complete Sections III and IV. If you wish to pay by cross-reference, **ONLY ONE** application is required. The person listed in *Section I: Demographic Information* will be the policyholder of the cross-reference payment option.

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION

Complete this section only if you are covering your eligible **spouse, dependent child(ren)** or have chosen the **cross-reference payment option** on your health insurance plan. Enter the required information for each dependent that you wish to cover. If you need additional space, use Page 1 of another health insurance application. Do not complete this section if you are selecting Single coverage.

Relationship Code: Enter the appropriate relationship code as follows:

- SP** Spouse (your eligible spouse).
CH Child (your eligible child, step child, adopted child, foster child or your grandchild that is considered your dependent and who is not disabled).
DD Disabled, Dependent Child (your eligible disabled child). If your disabled dependent child is 24 years old or older, your health insurance carrier will request evidence of his/her disability annually.
CO Court Ordered Dependent Child (an eligible dependent child that you are court ordered to carry on your health insurance or an eligible dependent child of whom you have full guardianship).

SECTION IV: SPOUSE'S CROSS-REFERENCE INFORMATION

Complete this section **ONLY** if you and your spouse are electing to pay by cross-reference.

- Enter your spouse's company number. **Required.**
- Enter your spouse's dual employee indicator, if applicable.
- Enter your spouse's smoking status. **Required.**
- Indicate whether or not your spouse is a hazardous duty retiree.
- Enter your spouse's hire date or retirement date, if applicable. This field is needed if the policyholder elects to start a cross-reference payment method when his/her spouse becomes employed or newly retired with an agency that participates in the Kentucky Employees Health Plan.
- Enter your spouse's deduction start date. This field is only needed if the policyholder elects to start a cross-reference payment method with a Board of Education employee.

SECTION V: CUSTODIAL PARENT INFORMATION

Complete this section if you have a **Court Order (CO)** or an **Administrative Order** to provide health insurance for an eligible dependent who does not live with you.

- Print your dependent's social security number in the boxes provided.
- Print the custodial parent's name and address in the lines provided. If the custodial parent is the same for each dependent, check the Yes box for "All Dependents?" and complete the custodial parent's name and address only once. If the custodial parent is different for each dependent, complete the appropriate information using an additional page. **Court Ordered dependents MUST also be listed in Section III.**

Health Insurance Application Instructions -- PAGE 2

KENTUCKY RETIREMENT SYSTEMS

Enter the social security number of the retiree in the spaces provided on the top left hand corner of Page 2.

Enter the social security number of the policyholder in the spaces provided on the top right hand corner of Page 2 (same as SSN in *Section I: Demographic Information*).

SECTION VI: NOT APPLICABLE

NOTE:

If a retiree elects to pay by cross-reference with an active spouse and the active spouse is eligible and would like to enroll in the state's Flexible Spending Account Program (Commonwealth Choice), the active spouse and the retiree should make their health coverage elections by completing the active spouse's health insurance application.

SECTION VII: AUTHORIZATION AND CERTIFICATION

Read the statements in this section carefully. After you have read and understood the statements, the retiree, if living, must sign on the "Retiree Signature" line and the applicant, if other than the retiree, must sign on the "Applicant Signature" line. Following each signature, enter today's date on the line provided.

If you are applying to pay by **cross-reference**, your **spouse MUST also sign** the application on the "Spouse Signature" line. He/she **must also enter today's date** in the line provided.

Your cross-referenced spouse must have his/her insurance coordinator sign this form before you return it to your insurance coordinator.

Your **cross-reference application** will not be processed without the **four required signatures and dates**: planholder, spouse, planholder's insurance coordinator and spouse's insurance coordinator.

GENERAL REMINDERS:

Do not hold your application until the end of open enrollment. Return your application to your retirement system as soon as possible.

If you are planning to pay by cross-reference, it is very important that you start the application process as early as possible. Again, your cross-reference application requires only one application with four different signatures.

Additional copies of the completed application may need to be made if paying by cross-reference to ensure that all parties maintain a copy for their records.